NACDD
State Diabetes Project

Evaluating Successes Findings and Recommendations

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Project Goal

By September 2013, eight state health departments will be engaged in statewide/regional efforts to promote increased use of the evidence-based lifestyle change program to prevent or delay the onset of type 2 diabetes among people at high risk.

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What we learned

- Project Description
  - Work completed per Strategic Focus Area
  - Technical Assistance and Training
- Results
  - Strategy-Specific Key Indicators
  - State Health Department Staff Competencies
- Key Findings
  - Facilitating Factors
  - Barriers
- State Health Department Roles

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Poised for Success

- Resources
- Identified diabetes prevention as priority
  - Internal/external champions onboard
  - Recommendations in key documents
- Capacity to work with the evidence-based lifestyle change program
  - Experienced staff
  - Connections with program providers
- Partnerships with organizations and/or people with expertise

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A Crosswalk: 1305 and S-DPP

1305 Strategy/Activity or Performance Measure (PM)	State DPP Strategic Focus Areas	
Promote awareness of prediabetes among people at high risk for type 2 diabetes	A	Raise Awareness: General Population and People at High Risk
	B	Raise Awareness: Providers
Increase use of lifestyle intervention program in community settings for the primary prevention of type 2 diabetes • Increase referrals to, use of, and /or reimbursement for the prevention of type 2 diabetes		
Participants in lifestyle change program who were referred by a healthcare provider (PM) Healthcare systems with policies or practices to refer (PM)	C	Healthcare Provider Referral
	D	Referral Systems
Medicaid recipients or state/local public health employees with access to lifestyle change program as covered health benefit (PM)	E	State/Local Government
	F	Business/Insurers
Six cross cutting core public health functions	G	Coordination and Alignment

Reach and Impact

Strategic Focus Area C: Healthcare Provider Referral		
Indicator	**Baseline**	**Total**
Number of healthcare system partners (overall system)	12	51
Number of healthcare delivery sites within the system partners (e.g. clinic/practice)	39	146
Number of primary care health providers (physicians, PA, and NP) in participating delivery sites	350	1,066
Number of adult patients served by participating healthcare delivery sites	0	313,655
Optional indicator: Number of adult patients in participating healthcare delivery sites referred to an evidence-based lifestyle change program	0	678
Strategic Focus Area D: Referral System		
Indicator	**Baseline**	**Total**
Number of system partners (overall system)	0	31
Number of adults with prediabetes living in geographic area covered by the referral system(s)	3,966	3,136,562
Optional indicator: Number of adults referred through the newly created referral system(s)	0	261

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State DPP Project Results: Awareness

Promote awareness of prediabetes among people at high risk for type 2 diabetes

4.3 million adults with prediabetes potentially reached through 10 awareness campaigns

Next steps

- Continue focus on increasing awareness
- Use CDC performance measure to track increased prevalence of prediabetes

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Promote Prediabetes Awareness

Facilitating Factors

- NACDD funds
- Engaged community and stakeholders early and throughout campaign
- Partnered with organizations and contractors to create awareness campaign, utilize existing infrastructure, and expand reach
- Engaged internal and external champions by asking them to make presentations
- Used or adapted existing materials from CDC, NACDD, or other State Health Departments
- Utilized expertise and support from other state health department programs,

Barriers

- Not enough time
  - Develop relationships
  - Identify the "right" partners and contractors
  - Contract process
  - Obtain or create materials
- Need to tailor materials for appropriateness to target audience

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State DPP Project Results: Healthcare System Policy or Practice

Healthcare systems have policies/practices to refer persons with prediabetes or at high risk

57 healthcare system partners

Additional data from 51 of these systems

146 delivery sites

1,066 healthcare providers

313,655 patients

Next steps

- Continue work with focus on implementation and sustainability
- Consider formalizing collection of referral numbers in addition to referral data from the CDC performance measure

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State DPP Project Results: Healthcare Provider Referral

Evidence-based lifestyle change program participants referred by their healthcare provider

678 adult patients were referred by their healthcare provider to the program (primarily in the 3rd and 4th quarter)

Next step - track provider referrals using CDC performance measure

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Increase Referrals

Facilitating Factors

- Provided funding to support referral process/system
- Established partnership with a known referral system
- Established relationships with health care clinics and providers
- Identified benefits from the provider's perspective
- Added new and diversified partnerships
- Frequently communicated with partners and contractors to tailor the effort and problem-solve

Barriers

- Project timeframe was too short to:
  - Contract
  - Establish relationships
  - Understand the clinic's structure
  - Develop referral processes and systems
  - Implement referral processes and systems
  - Collect referral data
- Challenges to get entre to healthcare providers/clinics
- Loss of resources
  - Staff
  - CDC funding

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State DPP Project Results: Covered Health Benefit/Government-sponsored

Medicaid recipients or state/local public employees with access to program as covered health benefit

State	Benefit Status	Covered Lives
Colorado	2013	44,011
Kentucky	2014	280,000
New Mexico	In process	3,500
Washington	2013	Not part of this project
TOTAL		327,511

Next steps

- States focus on enrollment and participation
- Use states as learning labs: other states and Medicaid

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Increase/Expand Reimbursement

Facilitating Factors

- Worked with partners with expertise in employee health and health benefits
  - Learned from them
  - Used their tools
  - Had them advocate and educate on the states' behalf
- Used demonstration program to show how the program works in their environment
- Highlighted how diabetes prevention was aligned with government priorities
- Shared materials and lessons learned from other states
- Capitalized on planned and unplanned opportunities to educate decision-makers

Barriers

- Health benefit cycle typically is longer than one year
- Is this the right time? Government, employers, and payers have competing priorities and are making multiple changes in the face of a great deal of uncertainty

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Alignment and Coordination

Facilitating Factors

- Strong foundation of relationships with existing lifestyle change program providers and other interested partners
- Access to resources and experts that could support the lifestyle change program provider
- Learned from and coordinated with other state chronic disease programs
- Used technology to support coordination and sharing lessons and resources

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Change in Project Competencies

- Training and Technical Assistance
  - NACDD
  - CDC
  - NBCH
  - DHPE
  - Each other
- Methods
  - Webinars
  - Learning Community
  - Individualized Communication
  - Site Visits

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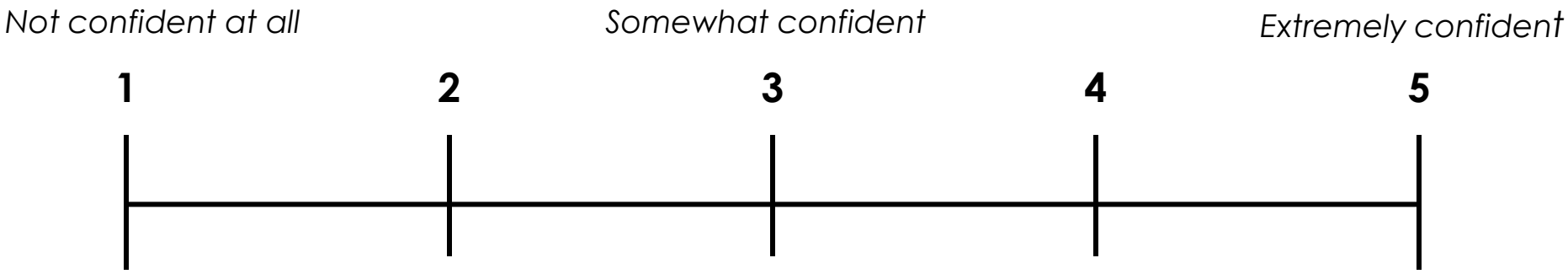
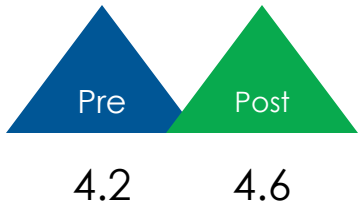
National DPP Evidence Base and DPRP Recognition

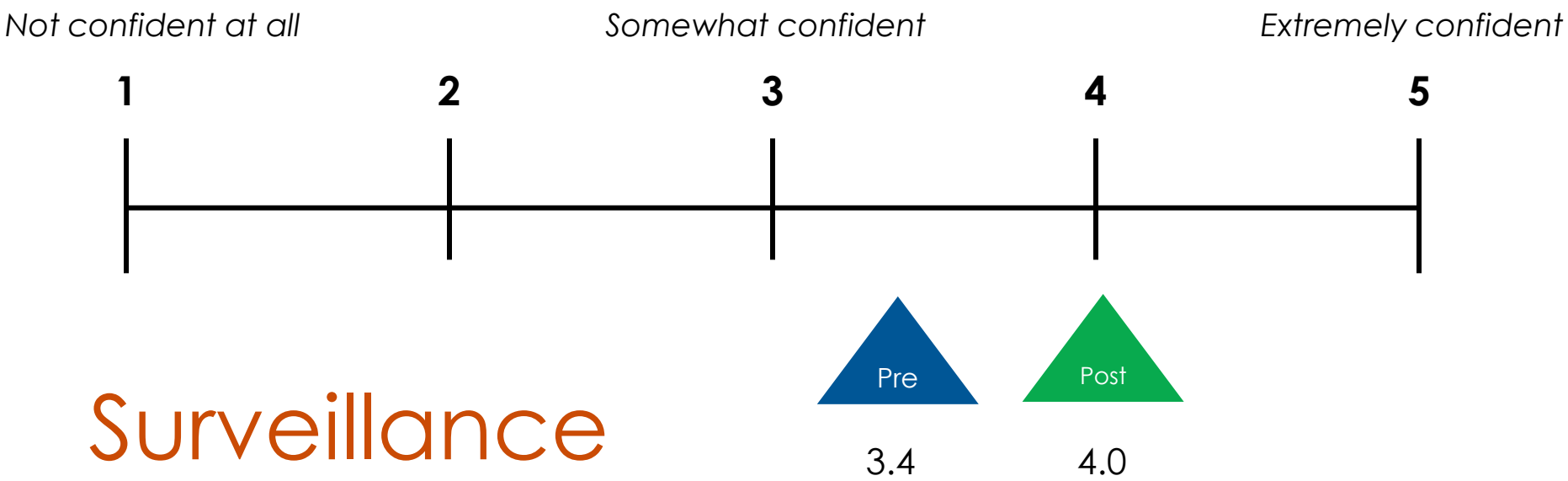




Workforce Development

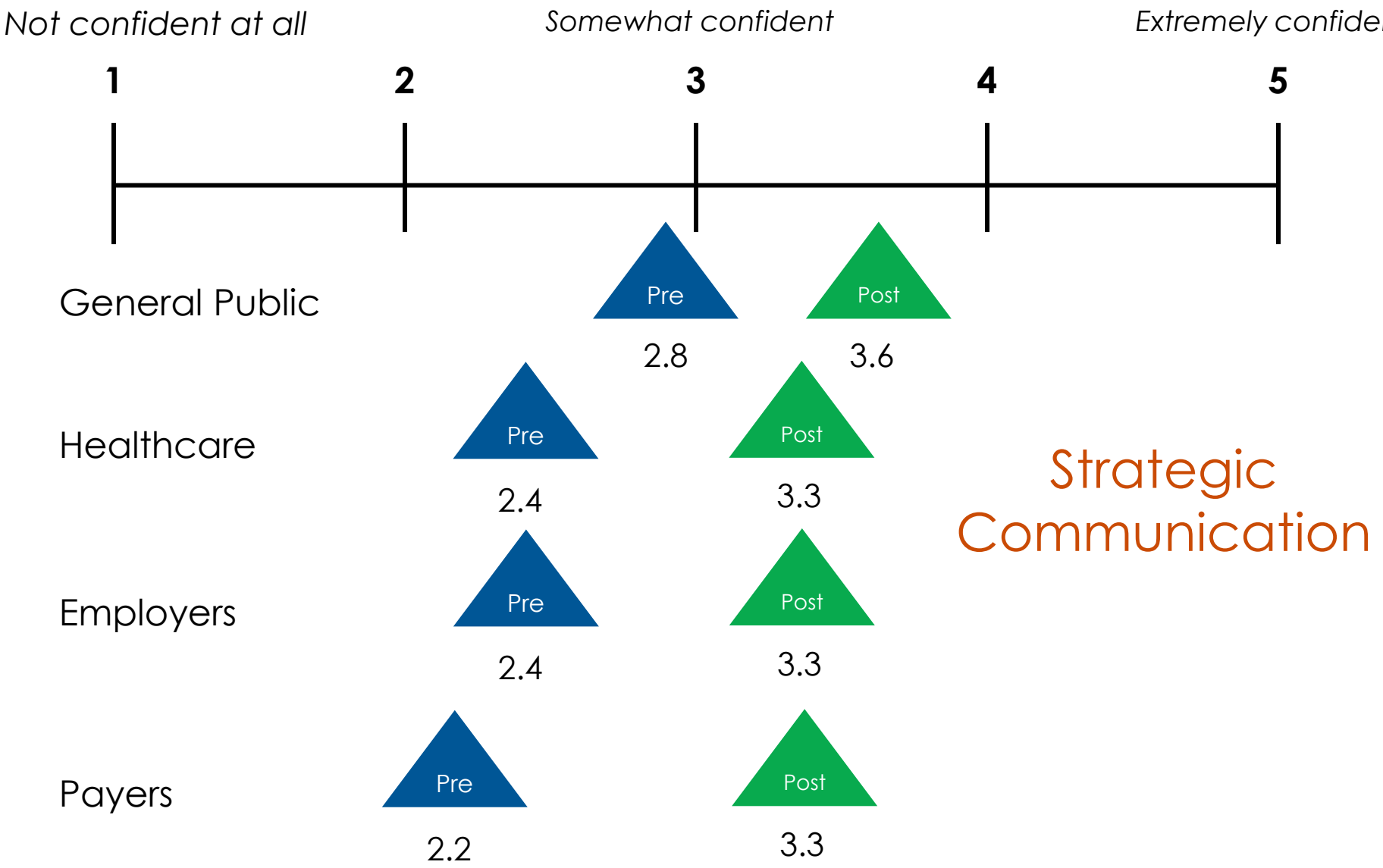
Guidance and Support

Use Data to Guide Programming

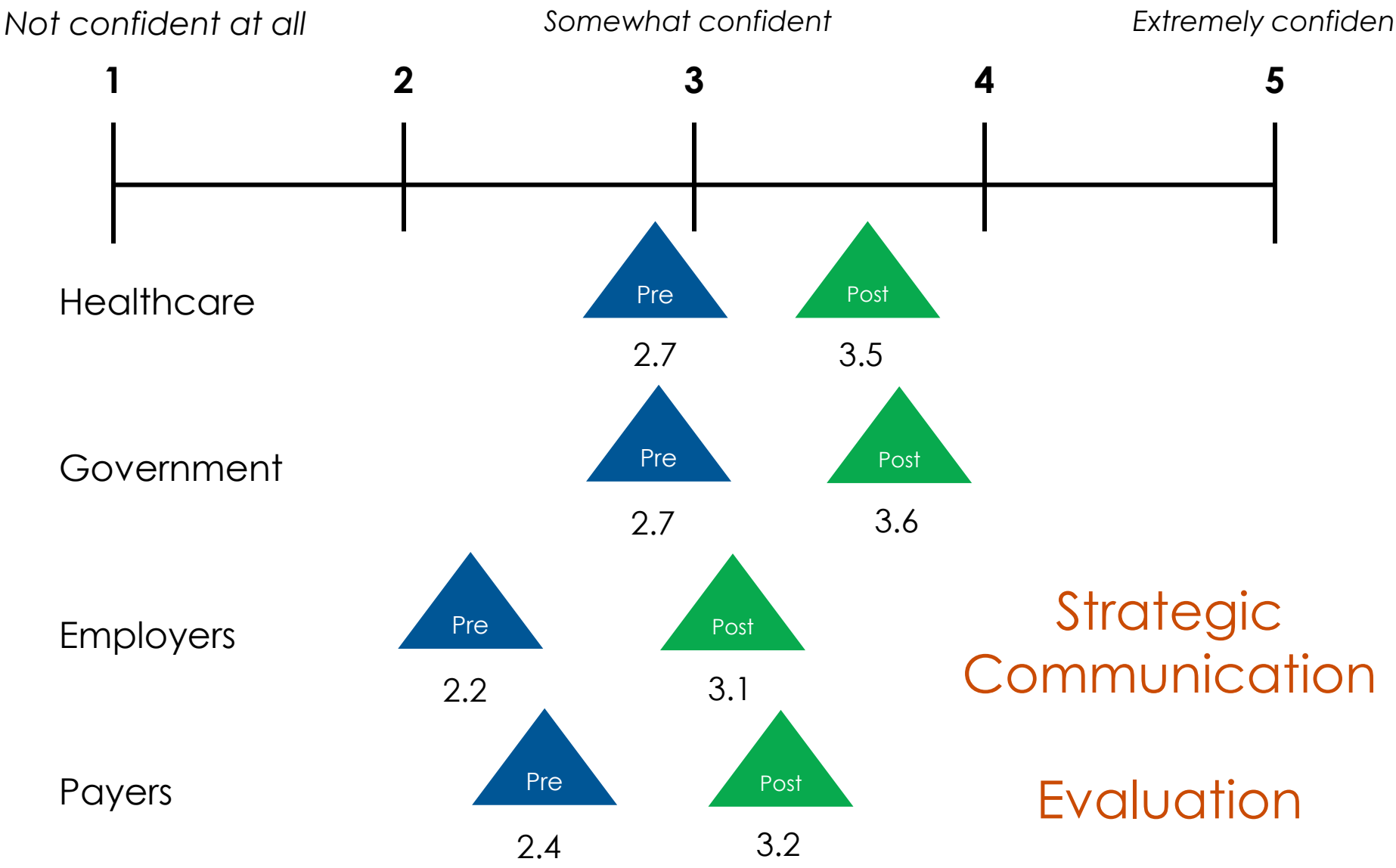


Surveillance and Epidemiology

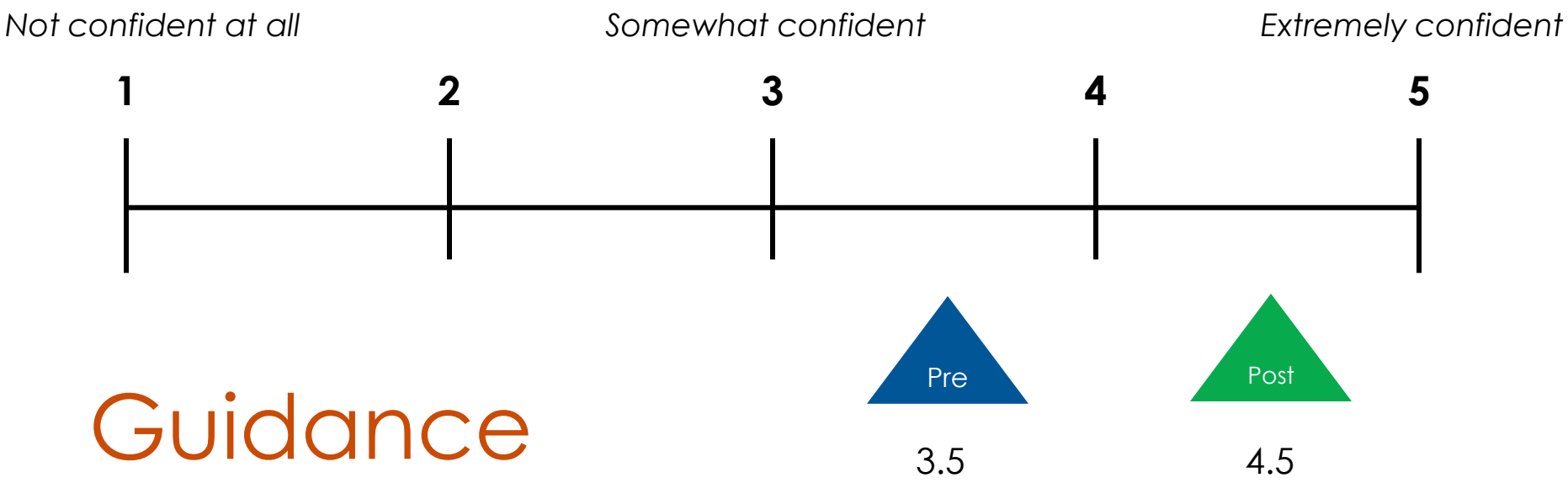
Marketing/Communication: Prediabetes Awareness



Present Business Case

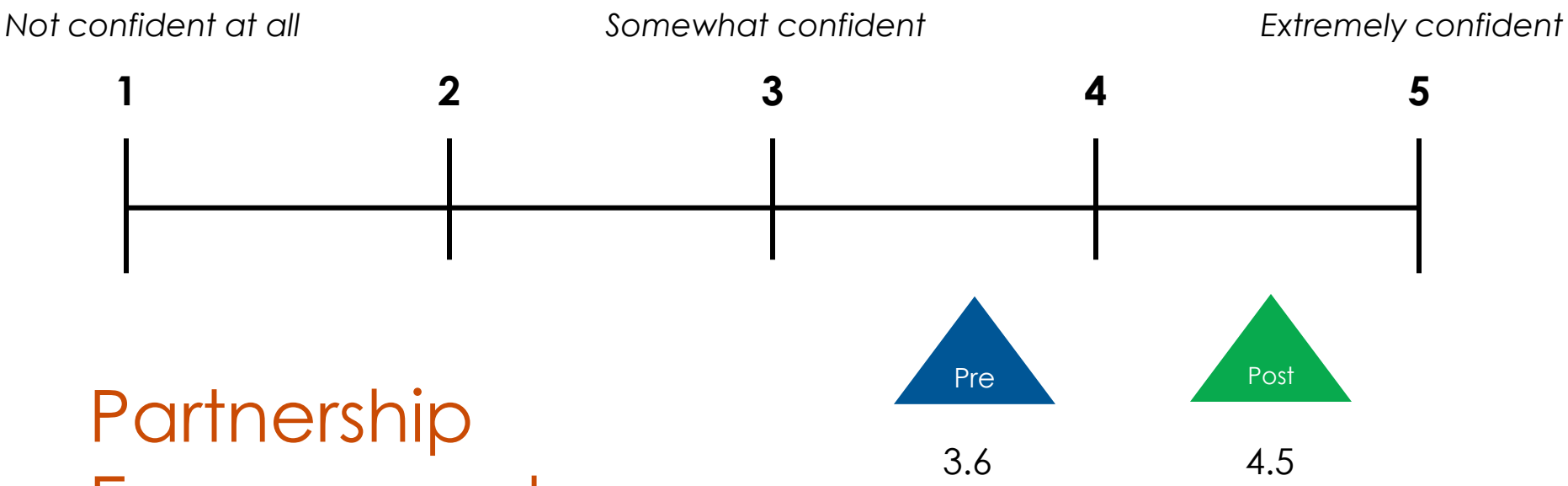


Science, Evidence-based, and Best Practices



Guidance and Support

Coordination and Alignment



Partnership Engagement

Guidance and Support

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What helped? **It takes a village!**

- Used funding and other resources to supplement the NACDD funding
- Engaged stakeholders early and throughout the project
- Leveraged internal and external partners with expertise, credibility and connections
- Cultivated high level support, including identification of champions
- Utilized existing network and relationships with evidence-based lifestyle change program providers
- Linked other evidence based programs with their diabetes prevention work to address diabetes-related needs across the continuum
- Linked with the CDC-funded National Diabetes Prevention Program grantees and their affiliates

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Barriers to Overcome

- Time and funding limitations
  - Overly optimistic project timeframe for implementation and sustainability
  - Limited funding, staff, and other resources
  - Loss of funding and staff
- Lacked experience, expertise and existing partnerships for their work with payers and employers (all states)
- Insufficient system to identify and remain current on the evidence-based lifestyle change program providers, especially upcoming program dates and locations (all states)

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State Roles

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Partnership Engagement

- Served as neutral convener
- Leveraged existing relationships and created new partnerships who provided experience and expertise

Workforce Development

- Provided technical assistance and content expertise

Guidance and Support

- Planned, coordinated, and executed all strategies
- Advocated for diabetes prevention at all levels and with all partners
- Linked strategies to state priorities and/or other prevention efforts
- Bridged diabetes prevention with diabetes self-management

Strategic Communication

- Engaged community members and stakeholders
- Identified program champions
- Informed key decision makers about diabetes prevention

Surveillance, Epidemiology, and Evaluation

- Organized demonstration of the evidence-based lifestyle change program – measure and communicate impact

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